

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-63-012889

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 310 Primary Registration District No. 605/ Registrar's No. 107

STATE FILE NUMBER

FILED APR 10 1963

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| 1. PLACE OF DEATH a. COUNTY <u>St. Charles</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Charles</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Portage Des Sioux</u> | | c. CITY OR TOWN <u>Portage Des Sioux</u> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Residence Portage Des Sioux</u> | | d. STREET ADDRESS (If outside, give location) <u>no street address.</u> | |

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| 3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>ELEANOR (NORA)</u> Last <u>TUCKER</u> | 4. DATE OF DEATH Month <u>March</u> Day <u>30</u> Year <u>1963</u> |
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| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <u>2-22-1874</u> | 9. AGE (last birthday) <u>89</u> | IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | IF UNDER 24 HR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> |
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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | 10b. KIND OF BUSINESS OR INDUSTRY <u>None</u> | 11. BIRTHPLACE (City and state or country) <u>Serona, Missouri</u> | 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u> |
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| 13a. FATHER'S NAME <u>Hagan</u> | 13b. MOTHER'S MAIDEN NAME <u>unknown</u> | 14. NAME OF HUSBAND OR WIFE <u>widow of Joseph Martin Tucker</u> |
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| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | 16. SOCIAL SECURITY NO. <u>None</u> | 17. INFORMANT Address <u>Jos. H. Tucker, Portage Des Sioux, Missouri</u> |
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| 18. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u> </u> DUE TO (c) <u> </u> | | INTERVAL BETWEEN ONSET AND DEATH <u>many years</u> |
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| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Hypertension</u> | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |
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| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) |
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| 20c. TIME OF INJURY Hour <u> </u> a.m. <u> </u> p.m. <u> </u> | 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 20f. CITY, TOWN, OR LOCATION COUNTY <u> </u> STATE <u> </u> |
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| 21. I attended the deceased from <u>2-24-63</u> to <u>3-20-63</u> and last saw her alive on <u>2-21-63</u> Death occurred at <u>3:30 P.M.</u> m on the date stated above, and to the best of my knowledge, from the causes stated. |
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| 22a. SIGNATURE <u>J. F. Commeyne M.D.</u> (Degree or title) | 22b. ADDRESS <u>St. Charles, Mo.</u> | 22c. DATE SIGNED <u>4-1-63</u> |
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| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u> | 23b. DATE <u>4-3-1963</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Hope Cemetery,</u> | 23d. LOCATION (City, town, or county) (State) <u>Perryville, Missouri</u> |
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| 24. FUNERAL DIRECTOR <u>Stock Mortuaries, 2117 E. Grand Bl.</u> | 25. DATE RECD. BY LOCAL REG. <u>4-1-63</u> | 26. REGISTRAR'S SIGNATURE <u>Marcella Wilson</u> |
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USE BLACK INK
OR
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

BY AFFIDAVIT OF

ITEM NO.

DATE AMENDED

VS 300
Rev. 4/59

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APR 11 1963

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Paul A. Wachtel

Licensed Embalmer No. 4287

P. O. Address Shawano, Wis.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.